MINNESOTA LIFE

NOTICE OF DISABILITY

Group Division Claims • P.O. Box 64114 • St. Paul, MN 55164-0114 • FOR CLAIM INFORMATION CALL: Toll Free **1 800 328-9442** – MN local **651-665-3815**

CLAIMANT'S STATEMENT. *To present your claim for benefits, complete the Claimant's Statement. All questions must be fully completed.*

PLEASE BE SURE TO SIGN AND DATE THE AUTHORIZATION ON THE REVERSE SIDE.

1. CLAIMANT'S LEGAL NAME (Last, First, Middle Initial)	2. TELEPHONE NUMBER ( )
3. PERMANENT ADDRESS (Street, City, State, Zip)	

4. HEIGHT	5. WEIGHT	6. DATE OF BIRTH (Mo/Day/Yr)	7. ☐ MALE ☐ FEMALE

8. GROUP POLICY NUMBER AND GROUP POLICYHOLDER	
9. WHAT WAS YOUR OCCUPATION PRIOR TO YOUR DISABILITY	10. DATE OF EMPLOYMENT
11. EMPLOYER'S NAME	12. SUPERVISOR'S NAME
13. EMPLOYER'S ADDRESS (Street, City, State, Zip)	14. TELEPHONE NUMBER ( )

15. DESCRIBE FULLY THE DUTIES YOU PERFORMED IN THAT OCCUPATION

16. WHAT WAS YOUR ANNUAL INCOME FROM YOUR OCCUPATION PRIOR TO YOUR DISABILITY $	17. WHAT IS IT NOW $	18. SOCIAL SECURITY NUMBER

19. CIRCLE THE NUMBER OF YEARS YOU HAVE COMPLETED IN

GRADE SCHOOL 1 2 3 4 5 6 7 8 HIGH SCHOOL 9 10 11 12 GED COLLEGE 1 2 3 4 VOCATIONAL TRAINING 1 2 3

20. WHAT DEGREES DO YOU HOLD

21. ARE YOU RECEIVING SOCIAL SECURITY, CIVIL SERVICE, ARMED FORCES, OR ANY OTHER DISABILITY BENEFIT

☐ Yes ☐ No IF SO, FROM WHAT SOURCE

22. WHAT SPECIAL SKILLS OR TRAINING DO YOU HAVE

23. PAST OCCUPATION JOB TITLES (List all prior jobs) IF NONE, PLEASE CHECK BOX ☐	STARTING EMPLOYMENT DATES	ENDING EMPLOYMENT DATES	JOB DUTIES

24. ON WHAT DATE DID YOUR INJURY OCCUR OR DISABILITY COMMENCE	25. ON WHAT DATE DID YOU LAST ACTIVELY PERFORM THE DUTIES OF YOUR JOB
26. ARE YOU NOW TOTALLY DISABLED AND UNABLE TO PERFORM YOUR JOB ☐ Yes ☐ No	27. WILL YOUR DISABILITY BE PERMANENT ☐ Yes ☐ No
28. IF NO, WHEN WILL YOU RESUME ALL OR PART OF YOUR WORK	29. IF PART, WHAT DUTIES

30. DESCRIBE FULLY THE NATURE OF THE DISEASE OR INJURY CAUSING YOUR DISABILITY

31. ARE YOU CURRENTLY ENROLLED IN A VOCATIONAL REHABILITATION PROGRAM ☐ Yes ☐ No	32. IF YES, LIST COUNSELOR'S NAME, ADDRESS AND TELEPHONE NUMBER	33. IF YOU ARE NOT CURRENTLY ENROLLED, DO YOU PLAN TO ATTEND A REHABILITATION PROGRAM IN THE FUTURE ☐ Yes ☐ No

WHEN DID YOU FIRST CONSULT A PHYSICIAN FOR YOUR DISABILITY

WHAT PHYSICIANS HAVE TREATED YOU FOR YOUR DISABILITY

NAME (Last, First, Middle Initial)	ADDRESS (Street, City, State, Zip)	
DIAGNOSIS		DATE (Mo/Day/Yr)
NAME (Last, First, Middle Initial)	ADDRESS (Street, City, State, Zip)	
DIAGNOSIS		DATE (Mo/Day/Yr)
NAME (Last, First, Middle Initial)	ADDRESS (Street, City, State, Zip)	
DIAGNOSIS		DATE (Mo/Day/Yr)

DATES OF HOSPITALIZATIONS

FROM / TO	HOSPITAL NAME	HOSPITAL ADDRESS
FROM / TO	HOSPITAL NAME	HOSPITAL ADDRESS

DESCRIBE FULLY ANY WORK YOU ARE NOW DOING OR YOUR CURRENT DAILY ACTIVITIES

REMARKS (You may use this space for any additional information you feel would be of help to us in evaluation of your claim.)

For the purpose of determining my eligibility for insurance coverage and benefits, I authorize any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge, including but not limited to my physical or mental health or financial information or employment, to give all such information it has to **Minnesota Life insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any health history including all consultations, diagnoses, prescriptions, treatments, test, as well as any information regarding alcohol or drug abuse, AIDS or AIDS-related conditions.

I authorize the Company to release any information relevant to my insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom I have coverage, or to any other public or private entity as may be required.

I AUTHORIZE: Minnesota Life Insurance Company to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) for subscriber insurers. An HCI report contains the date(s) of past or present claims filed by me and the names of the companies but does not contain medical or other personal information. I understand **Minnesota Life Insurance Company** will report to MIB the date(s) of any past or present clams filed by me.

Upon receipt of a request from me, MIB will arrange a disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is PO Box 105, Essex Station, Boston MA 02112, telephone number (617) 426-3660.

This authorization shall be valid for 30 months from date it is signed. I have read and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original.

SIGNATURE OF INSURED	DATE SIGNED
X	

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

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